

Parent Participation With Preschool Children  
In A Substance Abuse Prevention Program

An Honors Thesis (ID 499)

by

Therese M. Gerhard

Thesis Director

Ellen J. Hahn

Ball State University

Muncie, Indiana

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# ABSTRACT

A number of researchers have found that curiosity and experimentation with alcohol and other drugs is beginning at an early age. This study assessed the effectiveness of a drug and alcohol prevention program for preschool children. Children whose parents participated in the program with them were compared with children whose parents did not participate with them. The Preschooler Attitude Assessment Instrument yielded data regarding knowledge, feelings, and attitudes. The knowledge subscale yielded a significant increase in knowledge for children whose parents participated in the program. The importance of parental influence on young children was recognized.

## INTRODUCTION

Drug and alcohol use and abuse have become widespread problems in the United States as well as in many other countries. This is not new information. Researchers, however, have found some disconcerting evidence associated with this prevalence of alcohol and drugs. It is clearly evident that younger and younger groups of children are experimenting with drugs and alcohol. A number of researchers have found that in many cases this curiosity and utilization of alcohol and drugs begin at the elementary level (Cohen, 1976; Daniels, 1970; Finn & O'Gorman, 1981; Hahn & Papazian, 1987; National Clearinghouse for Alcohol Information [NCALI], 1985).

The question then becomes, "How can young children best be taught about alcohol, tobacco, and other drugs"? Tennant (1979) suggested that in order to have an impact, children's attitudes and beliefs must be influenced before a critical age is reached at which time these attitudes and beliefs may become fixed. Preschool children appear to be a suitable group with which to begin prevention education because they show "considerable awareness of substance abuse and other health-related behaviors" (p. 126). Finn and O'Gorman (1981) also suggested that good attitudes toward drinking are best established at an early age. They stated that "by the time some youngsters enter high school

and even junior high school, many of their feelings about drinking have 'hardened' and are less amenable to change in response to new information and insights than when these youths were younger" (p. 54).

McCormick (1976) was another advocate of preschool health education. She, again, proposed that it is during this time that children's habits concerning health are formed, including attitudes about alcohol and drug utilization. The most important influence for the child during these preadolescent years is the child's parents (Chen & Winder, 1986; Cohen, 1976; Daniels, 1970; Finn & O'Gorman, 1981; Garfield & Gibbs, 1982; McCormick, 1976; Newcomb & Bentler, 1988; Oei & Feam 1987; Parcel, Bruhn, & Murray, 1984; Sheppard, Goodstadt, & Willett, 1987; Shute, St. Pierre, & Lubell, 1981). McCormick (1976) continued, "Parents' influence is both overt, as expressed in their direct admonitions to the child, and covert, as reflected daily in their own behavioral patterns" (p. 28). This covert influence is in accordance with Bandura's (1969) Social Learning Theory in which the child models or imitates the behaviors, attitudes, and personality characteristics of the members of his/her social environment. During the preschool and early elementary years, the parents are the most salient members of the child's social environment.

Ultimately, then, the best means of educating young children is to involve the children's parents. McCormick (1976) insisted that "unless the teacher has developed a good relationship with

the child's parents, which includes a mechanism for impacting their attitudes and behaviors, the teacher's efforts as a health educator will not be effective" (p. 28).

Sheppard, Goodstadt, and Willet (1987) suggested that parental influences are most effective when developed in advance of adolescence. It is during adolescence that the peer group becomes important and the impact of parental as well as teacher influence diminishes (Newcomb & Bentler, 1988; Oei & Fea, 1987). According to the Report to Congress and the White House on the Nature and Effectiveness of Federal, State, and Local Drug Prevention/Education Programs (1987), "the development of strategies to obtain and keep a broader spectrum of parents involved in these [prevention] activities should be a priority" (p. 33).

It is evident, then, that open lines of communication must exist between parents and children in order for parental values and beliefs to exert their most significant impact. Bush and Davidson (1982) asserted that this communication is especially important between the mother and the child because of the child's emotional attachment to the mother. Oetting and Beauvais (1987) also stressed the importance of communication in the family. They suggested that "even if the family is caring and intact, unless that family communicates strong sanctions against drug use, it loses some of its potency" (p. 210).

A study conducted by Shain, Suurvali, and Kilty (1980) yielded some interesting information concerning parent-child

communication. Their study included a course for parents referred to as the Parent Communication Project (PCP). The course was designed to improve communication skills between parents and their children. Results of the study indicate the following:

The effect of the PCP skills is to legitimize and thus potentiate the alcohol-using behavior of parents in their children. Consequently, if mother and father drink and exercise PCP skills, children are likely to copy them more than if such parental skills were not exercised: if mother and father are abstinent and exercise PCP skills, the chances are raised that children will copy this behavior instead (Shain, Suurvali, & Kilty, 1980, p. 60).

Communication, then, is important between parents who encourage healthy living and their children, but what about parents who are users or abusers of tobacco, alcohol, or other drugs? There have been a number of studies analyzing smoking (Chen & Winder, 1986; Oei & Fea, 1987; Parcel, Bruhb, & Murray, 1984; Shute, St. Pierre, & Lubell, 1981; Tennant, 1969) and drinking behavior (Finn & O'Gorman, 1981; Sheppard & Taylor, 1986) that consider this question.

Oei and Fea (1987), for example, were strong advocates of parental involvement in the prevention of smoking in children. The child's most significant influence, they asserted, is the family. The child models the behaviors of older family members especially the parents, and if smoking is one of the behaviors the child observes, he is likely to integrate this behavior into his own. Therefore, it is important to educate the parent. If the parent understands the significance of his influence upon the

child, perhaps he can adapt a healthy lifestyle and stress the importance of healthy living.

This, however, is a difficult task because as Oei and Fea (1987) pointed out, "regular smokers are not very receptive to intervention" (p. 29). Children should receive early prevention education so that smoking behavior can be prevented before it begins. However, during the preschool and early elementary years, parents have a much greater influence over the child than do his teachers. Parcel, Bruhn, and Murray (1984) suggested that "education at school will only be one factor among many that will influence a child's behavior. In fact, other factors within the child's home and larger community environment may be much more influential and powerful, thus cancelling out the potential impact of school health education" (p. 55). How, then, can educators teach a child about the importance of not smoking when the child's parent or parents smoke? The parent must become involved in smoking prevention education.

Similar findings have been substantiated with alcohol and drinking. Finn and O'Gorman (1981) contended that "the value placed on alcohol use, like other values, is first learned in the home" (p. 34). When the parent does or does not engage in excessive drinking behavior for whatever reason, the child will initially drink or not drink in the same way. Sheppard and Taylor (1986) suggested that alcohol education occurs in the home as well as the school in that children see how family members use alcohol. More broadly, Daniels (1970) asserted:

Children entering Kindergarten have already had five years of drug education that began the day they were born into our drug oriented society. Preschoolers are quick to learn at home by observing and imitating the attitudes and practices of members of their immediate families, including those involving drug use or abuse (p. 243).

Sheppard and Taylor (1986) suggested that children be educated about the role of alcohol in society. For the child whose parents drink or smoke or use drugs, saying only negative things to that child about such practices will only succeed in confusing the child. Because parents are such important figures in the child's life, promoting understanding and parental involvement will have the best possible impact on the child. Pratt, Eilson, and Wright (1987) and McCune (1972) contended that the combined efforts of the schools, family, and community exert the most significant impact upon drug abuse.

#### PURPOSE OF THE STUDY

The purpose of this study was to test the effectiveness of a drug and alcohol prevention program for preschool children with children whose parents participated in the program as compared to children whose parents did not participate in the program. There were two proposed hypotheses:

1. There will be a significant increase in preschoolers' knowledge, correct feelings, and correct attitudes toward alcohol, tobacco, and other drugs after participating in the prevention program.
2. Children whose parents participate at high levels in the program will experience a significant increase in knowledge,



correct feelings, and correct attitudes toward alcohol, tobacco, and other drugs after participating in the prevention program.

#### METHOD

##### Subjects

The convenience sample consisted of 37 preschool children enrolled at two Head Start Centers in Muncie, Indiana. There were 20 girls and 17 boys. All children were four or five years old.

The convenience sample consisted of 37 parents, or primary caretakers, of one of the above 37 preschoolers. In most cases, the parent was the child's mother. The majority (52 %) of the parents were white. Over one third (37%) were black. A large majority (96%) of the parents had annual incomes of less than \$10,000. Almost three fourths (72%) had annual incomes of less than \$5,000.

##### Instrumentation

The instrument used for this study was the Preschooler Attitude Assessment Instrument (PreAAI) developed by Hahn and Papazian (Copyright, Ball State University, 1987). The PreAAI is a pictorial instrument which utilizes three subscales to assess preschool children's knowledge, feelings, and attitudes about alcohol, tobacco, and drugs.

The PreAAI consists of eleven test picture, three control pictures, and three practice pictures. In each picture, a young bear named Bunchy is seen with a parent, a larger bear. In each picture, Bunchy observes the parent engaging in some type of

activity such as eating a sandwich (control), smoking a cigarette (test), or giving Bunchy a drink of beer (test). All test pictures involve the use of alcohol, tobacco, or other drugs. The child is asked three questions about each picture: 1) What is the parent doing in this picture? 2) How does Bunchy feel? and 3) Does Bunchy think this is good or bad? The first question assesses the child's knowledge, the second his feelings, and the third his attitude. The child's answers are recorded on a standardized coding sheet.

In order to assess the stability reliability of the instrument, a test-retest method was used. Two weeks after initial testing, the children were tested again. Pearson correlation coefficients indicated that the instrument was reliable over time (knowledge,  $r=.60$ , attitudes,  $r=.73$ , feelings,  $r=.70$ ). Internal consistency was determined for the Knowledge subscale with a Cronbach alpha of .57.

Interrater reliability was also established. In order to insure consistency between testers, an extensive training session was conducted. During this session, each tester was given a manual discussing in detail the development and proper usage of the PreAAI. A video tape consisting of actual examples of children being tested was also viewed by the testers. The testers were asked to practice by filling in coding sheets as they would in an actual testing situation. The coded data was then checked and discussed so that all testers agreed on the correct coding. The average percentage of agreement between

raters ranged from 94-98%.

### Collection of Data

The testing of the children was done in a quiet room at each testing site. A rapport-building game was played with a group of five children. This was done to familiarize the children with the tester and to alleviate any apprehension. During this time the children were introduced to Bunchy Bear. They were shown one of the three practice pictures of Bunchy and his parent and as a group were asked the three test questions about the picture. The children were then taken individually by the tester back to the testing room to answer questions about all of the pictures. Each session lasted approximately ten to fifteen minutes. All children were tested and then retested again two weeks later.

### Intervention

The substance abuse prevention program utilized in this study was Beginning Alcohol and Addictions Basic Education Studies (BABES). BABES, a division of the National Council on Alcoholism, is a prevention program designed primarily for preschool and elementary school children. The program consists of seven lessons which attempt to teach children positive living skills. Topics presented include self-image, expression of feelings, decision-making, peer pressure, and coping skills. Information about alcohol and drugs is carefully integrated into each lesson as well as being the central focus of one entire lesson.

During each lesson, puppets are used to illustrate a story

about positive living skills. During these stories, information about alcohol and drugs is presented in an accurate, non-judgmental manner. Children are encouraged to participate in the lessons by singing songs, holding the puppets, and completing worksheets.

Parents were encouraged to participate with their child. Several flyers were sent home with the children inviting and reminding the parents to attend the BABES sessions. Notices were also posted at the Head Start sites. Teachers were asked to encourage parents and were enthusiastic about helping.

#### Treatment of Data

Posttest data was collected after the BABES lessons in the same manner that it was collected during the test and retest phases. Data from each subscale was analyzed. For analysis purposes, data from the knowledge subscale was coded correct, incorrect, or undecided. Data from the feelings subscale was coded happy, sad, mad, other, or undecided with sad or mad representing a correct response. Data from the attitude subscale was coded good, bad, or undecided with bad representing a correct response. Data from ten of the eleven test pictures was analyzed. The picture depicting Bunchy's parent injecting drugs was omitted ~~out~~ because none of the children correctly identified the picture. To determine differences between participation levels and across time, MANOVA (spssx) was used to analyze the data.

## RESULTS

Results indicated that children's overall knowledge increased significantly from test to posttest (see Table 1). It was unclear whether this increase in knowledge was due to the BABES program or to a testing effect from the instrument, as the same pictures were utilized during each of the three testing phases. Changes in the attitude and feelings subscales were insignificant, although there was an increase in correct attitudes from test to posttest.

When analyzing parent participation data, significant results were found for the knowledge subscale (See Fig. 1). Parent participation was defined as no-low (0-2 BABES lessons) or high (3-7 BABES lessons). Of the 37 parents, 27 were classified as no-low participants and 10 were classified as high participants. Children's knowledge increased significantly from test to posttest for those children whose parents were high participants ( $p \leq .001$ ).

## CONCLUSIONS

The results of this study supported the initial hypotheses for the knowledge subscale. The following conclusions were made:

1. All children experienced an increase in knowledge toward alcohol, tobacco, and other drugs after participating in the prevention program.
2. Children whose parents participated with them in the program experienced a significant increase in knowledge toward

alcohol, tobacco, and other drugs at posttest.

#### DISCUSSION

Although the results of this study indicated that preschoolers experienced a significant increase in knowledge after participating in a substance abuse prevention program, it cannot be concluded that this increase was a direct result of the prevention program itself. The increase in knowledge could have been partly attributed to a testing effect of the instrument because the same pictures were used during the three testing sessions. An analysis utilizing a control group would be necessary in order to evaluate the effectiveness of such a program.

It is evident, however, that parent participation had a significant effect on preschooler performance on the knowledge subscale. Thus, the extreme importance of parental influence is recognized. Educators should encourage parent participation in the monumental task of preventing alcohol and drug abuse. This point was emphasized by Dupont, the former Director of National Institute of Drug Abuse, when he said, "The most important new frontier in primary prevention of drug abuse is parent power. It is ironic that after a decade of parent put-downs, we are rediscovering that parents, who were written off as ignorant and meddlesome at best, and as the problem at worst, are now the solution to the drug problem" (cited in Oei & Fea, p. 38).

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Table 1

Results for Complete Sample (n=37)

Knowledge	
Mean Correct Response out of Ten	
Test	2.784
Post-test	3.676 *
Attitude	
Percentage Responding "Bad"	
Test	54
Post-test	59
Feelings	
Percentage Responding "Sad" or "Mad"	
Test	54
Post-test	51

\* ( $p \leq .001$ )

Figure Caption

Figure 1. Results according to parent participation. A significant difference is noted for high participants.

